PEER GROUP ADMINISTRATIVE ADJUSTMENTS

A. A provider may request an AA of the reimbursement limits specified in this Section of the Plan and their peer group placement at the time of tentative and final PIRL settlement.

1) The request shall be made within 90 days after notification of the reimbursement limits and shall be made in accordance with the procedures specified in Section VI. of this Plan.

2) The burden of proof shall be on the provider to prove that the additional reimbursement sought meets all of the requirements under Section VI. and that except where a specific formula in Section XI. exists, the provider's cost per discharge of the item being appealed, exceeds the 60th percentile cost per discharge of the item being appealed.

3) In addition to the items listed under Section VI. B. of this Plan, the following items shall not be subject to an AA of the PGRPDL:

(a) The use of hospital peer groups.

(b) The use of 60th percentiles and the methods used to compute them.

(c) Changes in case mix.

(d) Costs associated with strikes other labor stoppages or slow downs.

(e) The addition of new services.

(f) Costs due to low occupancy.

(g) Difference in the type, nature, or scope of items or services available whether or not provided, between the provider and other providers in its peer group since differences in the actual services needed to be rendered are accounted for in the CMA as specified in Section XI. of this Plan.

(h) Any other issue that is not a difference between the provider and other providers in their peer group.

4) A provider may appeal the Department's decision on the AA for final PIRL settlements only. The appeal shall be in accordance with Section VIII. of this Plan.

XI. PEER GROUP SPECIFIC ADMINISTRATIVE ADJUSTMENT ISSUE

A. Differences in case mix (including outliers) between the provider and other providers in its peer group shall be determined for the PGRPDL using the following formula, but subject to reduction for overlapping issues as specified in D. below:

MARD=PGL * CMA

Where: MARD=Maximum Allowable Rate Per Discharge under the PGRPDL.

CMA=Case mix adjustment factor, which is the providers case mix index divided by the peer group 60th percentile case mix index.

PGL=Peer grouping reimbursement limit per discharge (60th percentile ARPD for the peer group if no adjustments have been made).

1) Case mix indexes shall be based on DRGs and shall be computed using OSHPD patient discharge data for providers. Providers with an ARPD CMAF shall use data they are required to supply for the ARPD CMAF. However, the set of DRG weights used must be consistent for all providers in the peer group and shall be determined by the Department for each FPE.

2) Providers shall be allowed to submit more accurate diagnosis and disposition data used to calculate the DRG case mix index. Any such patient discharge data must be submitted with the AAR. The data cannot be used until it is verified by the Department. The Department shall not accept data that it determines may not accurately reflect the provider's Medi-Cal patients.

3) If OSHPD patient discharge data does not correspond with all provider's FPE the closest FPE shall be used. Indices will be developed for a calendar year and for a July 1 through June 30 FPE. The period which most closely corresponds to the providers' FPE shall be used. Calendar year data shall be used for FPEs from October 1 through March 31 inclusive. July 1 through June 30 fiscal period data shall be used for all other FPEs.

4) CMAs may be applied to any provider with a case mix index greater than the 60th percentile case mix index of its peer group.

5) In addition to case mix relief, a provider shall be granted relief for outliers if the provider's outlier relief per discharge is greater than the computed 60th percentile outlier relief per discharge for all providers in the provider's peer group. The methodology used shall be as follows:

   (a) Using OSHPD patient discharge data, and Medicare criteria for DRG outlier relief as specified in 42 CFR, Part 412, compute the total outlier relief for all providers in each peer group (using the same formula as listed in Section VII. ARPD case mix and outliers). However, the cost outlier cutoff shall not vary within any one FPE worth of data.

   (b) Convert the results under 1) above to outlier relief per Medi-Cal discharge.

   (c) Align the results of (b) above, in order from lowest at the bottom up to the highest at the top, and by counting up from the bottom to the n + 1 provider (n = # of providers in the peer group), compute the 60th percentile outlier relief per discharge for each peer group.

   (d) If the requesting providers outlier relief per discharge is greater than the 60th percentile outlier relief per discharge, the provider's MARD shall be increased by the difference of the two figures.

6) These formulas shall be subject to the following limitations:

   (a) Only those providers with 30 or more Medi-Cal discharges shall be included in the calculation of the 60th percentile outlier and case mix index per discharge. However, providers with under 30 Medi-Cal discharges may still receive relief using the formulas in this Part.

   (b) Providers whose Medi-Cal discharge count per their OSHPD patient discharge data has more than a 50 percent variance from the appropriate Medi-Cal discharge figure from the cost report, after

adjusting for well newborns who are included in the OSHPD patient discharge data but not counted as Medi-Cal discharges, shall be excluded from the 60th percentile calculation. Cost report figures shall be adjusted to estimate the calendar or fiscal period OSHPD data.

(c) If the provider requesting outlier relief has more than a 10 percent variance in Medi-Cal discharge figures (OSHPD patient discharge data vs. Medi-Cal cost report), or under 30 Medi-Cal discharges, the provider shall be required to submit its own data for use in the calculation. Such data must be for all Medi-Cal patients and include the patient's last name, ICD-9 primary diagnosis code, admission date, discharge date, DRG number, charges, patient's age, and OSHPD disposition code. The list shall be in admission date order.

(d) Providers may submit additional data to replace the OSHPD data. Any such data must be supplied with the AAR. Providers must supply a list in admission date order, containing each Medi-Cal patient's last name, ICD-9 code, admission date, discharge date, DRG number, charges, patient's age, and OSHPD disposition code.

7) For noncontracting hospitals that do not keep a patient for the full episode of care, the CMA formula will be modified by one of the following formulas:

(a) Use only 40 percent of the appropriate DRG case mix weight for patients treated by noncontract hospitals, or

(b) (1) Track each patient's record to the contract hospital they were transferred to, and

(2) Sum the charges from both providers, and

(3) Apply the percent of total charges from the noncontract hospital to the DRG weight.

B. Differences in labor costs, caused by factors such as differences in location, between the provider and other providers in its peer group shall be calculated using the following formula, subject to reduction for overlapping issues as specified in D. below:

MARD = (LRCAF * WRR * PGL) + ((1-WRR) * PGL))

Where:

MARD = Maximum Allowable Rate Per Discharge under PGRPDL

LRCAF = Labor Related Cost Adjustment Factor, which is the minimum of (WI / PGWI), (HWR / PGWR) and (HWD / PGWD).

WRR = Wage Related Reimbursement Proportion of PGRPD (and ARPD) Reimbursement limitation for this hospital, which is: (TWRC / GOE) * (36LIMIT - %PASS * NETCOST)) / (36LIMIT * %NON).

PGL = Peer group limit, which is the 60th percentile ARPD.

WI = The wage and benefit index for the area in which the hospital is located.

PGWI = Peer group 60th percentile WI.

HWR = Hospital aligned wage and benefit rate per hour.

PGWR = Peer group 60th percentile HWR.

HWD = Hospital aligned wage related items per discharge.

PGWD = Peer Group 60th percentile HWD.

TWRC = Total wage related costs (sum of wages, benefits, and professional fees).

GOE = Gross operating expenses.

36 LIMIT = Maximum reimbursement under MIRL (lesser of costs, charges, and the ARPD multiplied by the number of Medi-Cal discharges).

%PASS = Proportion of GOE which are pass throughs from Report E, Part II, Line 3.

NETCOST = The lesser of net cost of covered services and charges.
%NON = 1 - %PASS, which is the proportion of GOE which are not pass-through costs.

NOTE: * = Multiplication

1) The labor adjustment formula starts by determining the portion of the MIRL that was allowed for Wage Related Reimbursement (WRR). Only this amount is adjusted by the minimum of:

   (a) A ratio based on an area (Metropolitan Statistical Area (MSA)) index developed by the Department of Health and Human Services, calculated using aligned average hourly rates for all hospital employees. The provider's area index is divided by the peer group 60th percentile wage index.

   (b) A ratio based on comparing the provider's aligned hourly rate to the 60th percentile aligned hourly rate of the peer group.

   (c) A ratio based on comparing the providers aligned wage related items per discharge to the 60th percentile aligned wage related items per discharge for the peer group.

2) The first ratio is calculated as follows:

   (a) Use Medi-Cal cost report data to determine the statewide average employee composition among all employee classifications.

   (b) Adjust the wage and benefit rates for each provider to the adjusted rate using the statewide distribution of employees.

   (c) Align the adjusted wage and benefit rate for each provider using OSHPD disclosure data. The alignment factors shall be a Department estimate of increases in salary levels.

   (d) Sum the adjusted wages and benefits for each MSA and statewide.

   (e) Sum productive hours by MSA and statewide.

   (f) Divide the sum of wages and benefits by the sum of productive hours for each MSA and the statewide totals.

   (g) Divide each MSA average aligned hourly wage rate by the statewide average to obtain an MSA index.

(h) Assign the index for each MSA to all hospitals in the MSA.

(i) Determine the 60th percentile index for each Peer Group.

(j) Divide the hospital's area index by the 60th percentile index of its peer group.

3) The second ratio is calculated by:

(a) Total the wages and benefits for all employees for each provider.

(b) Divide (a) above by the corresponding total productive hours for each provider.

(c) The Department shall estimate increases in employee hourly wage and benefit costs, and align the data in (b) above to a common FPE for all providers.

(d) Align all of the results of (c) above ordered from lowest at the bottom to the highest at the top for each peer group.

(e) Count (0.6 * (n + 1)) places up from the bottom of the list in each peer group to find the 60th percentile.

(f) N is the number of hourly rates in the peer group.

(g) Interpolation will be used whenever (0.6 * (n + 1)) is not a whole number.

4) The last ratio is calculated by:

(a) Total the wages and benefits for all employees for each provider.

(b) Using Department estimates of rates of increase in employee hourly wages and benefit costs, align the data in (a) above to a common FPE for all providers.

(c) Divide the result of (b) above by the number of total hospital discharges.

(d) For each peer group, order from lowest at the bottom to the highest at the top the results of (c) above.

(e) Count (.6 * (n + 1)) places up from the bottom of the list in each group to find the 60th percentile.

(f) N is the number of wage and benefit rates per discharge in the peer group.

(g) Interpolation will be used whenever (.6 * (n + 1)) is not a whole number.

C. Differences in capital costs between the provider and other providers in its peer group shall be resolved using the method specified in this subsection. Approval by the OSHPD of a capital expenditure shall be evidence of the need for the capital expenditure; however, such approval shall not, per se, compel additional reimbursement. The following methods shall be used to calculate relief under this issue:

Cap'l Exp

1) Using data from the Medi-Cal cost report, compute relief by:

(a) Removing the 60th percentile capital cost per discharge from the 60th percentile allowable rate per discharge,

(b) Computing the allowable provider Medi-Cal capital expense per discharge subject to the limitations in (e) below, and

(c) Adding the result of (a) above to the result of (b) above.

(d) The resulting figure from (c) above will be used in place of the 60th percentile rate per discharge, but to avoid overlap with any other issue, this adjustment shall be made last.

(e) The result of 1) (b) above shall be subject to the following adjustments:

1. A hospital which has had a change of ownership (CHOW) on or after July 18, 1984, must submit data showing what its capital costs would have been had the CHOW not occurred except for any additional costs allowed under the Deficit Reduction Act of 1984. This capital cost

amount shall be used when computing the provider's capital per discharge figure above.

2. If a provider has had its capital costs reduced by Medicare, the provider's capital expense per discharge (CEPD) shall be reduced by the Medicare capital cost reduction percentage.

   The formula for relief would then be:

   MPGRPD = (PGRPD - 60th percentile CEPD) + (X * hospital CEPD)

   Where: X = 1 minus the Medicare payment reduction percentage

3. If a provider's capital expense per discharge is above the 60th percentile, it shall not be entitled to automatic relief. The provider must still prove that the capital expenses are necessary for the care of Medi-Cal patients.

D. Providers which are eligible for any multiple adjustments under Sections X. through XI. of this Plan shall have relief computed using the following methodologies:

1) For providers which are eligible for case mix, labor and capital adjustments, relief shall be computed as follows:

   MPGRPD = MAX(CMA,LRCAF,MIN ((CMA*(WI/PGWI)),(HWD/PGWD))) * WRR * PGRPD) +

   (CMA * (1 - CRC - WRR) * PGRPD) + CEPD

   Where: CRC = Capital related cost percentage (CEPD/GOE)
   MIN= Minimum of the items in parentheses
   MAX= Maximum of the items in parentheses

   If the provider's CEPD has been modified per Section XI. C. 2. above, that revised figure shall be substituted into the formula above.

2) For providers which are entitled to a CMA but whose capital and/or labor costs per discharge are below the 60th percentile, those cost components shall not be adjusted by the CMF. The formula for relief shall be:

MPGRPD = ((PGRPD - 60th percentile CEPD - 60th percentile labor per discharge) * CMA) + hospital CEPD + hospital labor per discharge

(a) This formula shall be modified to remove only those costs (labor and/or capital) which are below the 60th percentile limit.

(b) A provider's reimbursement, pursuant to the above, shall not be adjusted below the 60th percentile rate per discharge.

(c) All other multiple adjustments shall have their overlapping relief calculated using the basic PGARPDL principles.

E. Differences in costs between the provider and other providers in its peer group due to extraordinary events beyond the provider's control such as fire, earthquake, flood, or similar unusual occurrences with substantial cost effects shall be an appealable item;

F. Differences in costs between the provider and other providers in its peer group caused by other items or circumstances affecting provider costs which meet all of the following criteria:

1) The item is a difference, on a per discharge basis, between the hospital and the 60th percentile of the peer group.

2) The item can be measured or estimated for all providers in the peer group.

3) The costs were necessary for the provision of quality medical care to Medi-Cal beneficiaries.

4) There is no overlap with other issues or the overlap can be measured.

G. Relief for any issue shall be reduced for any overlap between issues.

H. Any additional reimbursement granted pursuant to this part of the Plan shall not result in a recalculation of the 60th percentile limit under Section IX. of this Plan.